EXHIBIT YY

(MUSC MEDICAL REQUESTS AND INVOICES)

GOODING AND GOODING
A PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW

265 BARNWELL HIGHWAY
CORNER OF BARNWELL HIGHWAY AND MEMORIAL AVENUE
POST OFFICE BOX 1000
ALLENDALE, SOUTH CAROLINA 29810

H. WOODROW GOODING
ELIZABETH KEARSE GOODING
MARK B. TINSLEY

LAINE BRABHAM GOODING

Telephone #
(803) 584-7676

Facsimile #
(803) 584-3614

December 30, 2013

Addressed - instructions 1/8/14

MUSC Medical Center
Health Information Services Dept.
ATTN: Release of Information
171 Ashley Avenue
Charleston, SC 29425-0768

Spoke to representative they have the request. the billing was processed on 1/3/14 & records 1/6. It will take 2wks for me to get.

Re:	Angela Reynolds
SS:	251-49-8037
DOB:	12/17/65
Date of Accident:	12/16/13

Dear Sir/Madam:

Please be advised that **GOODING AND GOODING, P.A.** represents the legal interest of the individual named above, as a result of injuries sustained in an automobile accident on the above referenced date. It is my understanding that our client received medical treatment at your facility **on or after 12/16/13**. I would appreciate your forwarding a copy of the **ER report and Admission report**. I am enclosing a medical authorization for the release of this information.

Sincerely,

Cherry M. Vick

Cherry M. Vick
Legal Assistant
to Mark B. Tinsley

/cmv
enc

GOODING AND GOODING
A PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW

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December 30, 2013

MUSC Health Info. Services
Attn: Copy Med
169 Ashley Ave.
P.O. Box 250349
Charleston, S.C. 29425

Re:	Angela Reynolds
SS:	251-49-8037
DOB:	12/17/65
Date of Accident:	12/16/13

Dear Sir/Madam:

Please be advised that **GOODING and GOODING, P.A.**, represents the above named individual as a result of injuries sustained in an automobile accident. It is our understanding that treatment was provided in your facility for these injuries on or after the above date. I would appreciate your forwarding an **ITEMIZED BILL** for **ER services and Admission** rendered on 12/16/13. I am enclosing a properly executed medical authorization for the release of this information.

Sincerely,

Cherry M. Vick

Cherry M. Vick
Legal Assistant
to Mark B. Tinsley

/cmv
enc

TRANSMISSION VERIFICATION REPORT

TIME : 01/13/2014 16:55
NAME : GOODING & GOODING
FAX : 8035843614
TEL : 8035847676
SER.# : BROA0J123686

DATE,TIME	01/13 16:54
FAX NO./NAME	18437925460
DURATION	00:01:16
PAGE(S)	04
RESULT	OK
MODE	STANDARD ECM

GOODING AND GOODING
A PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW

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POST OFFICE BOX 1000
ALLENDALE, SOUTH CAROLINA 29810

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Telephone #
(803) 584-7676

Facsimile #
(803) 584-3614

DATE: January 13, 2014

TO: Release of Information
MUSC

FAX NO: 843-792-5460

FROM: Cherry M. Vick, Legal Assistant
Gooding and Gooding

NUMBER OF PAGES: 4 (Including cover sheet)

Re: Angela Reynolds
SS: 251-49-8037
DOB: 12/17/65
Date of Accident: 12/16/13

GOODING AND GOODING
A PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW

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ALLENDALE, SOUTH CAROLINA 29810

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IF YOU SHOULD HAVE ANY PROBLEMS WITH THE TRANSMISSION OF THIS DOCUMENT, PLEASE CALL Cherry Vick AT (803) 584-7676.

GOODING AND GOODING
A PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW

265 BARNWELL HIGHWAY
CORNER OF BARNWELL HIGHWAY AND MEMORIAL AVENUE
POST OFFICE BOX 1000
ALLENDALE, SOUTH CAROLINA 29810

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January 13, 2014

VIA FACSIMILE 843-792-5460
MUSC Medical Center
Health Information Services Dept.
ATTN: Release of Information
169 Ashley Avenue
Charleston, SC 29425-0768

Re:	Angela Reynolds
SS:	251-49-8037
DOB:	12/17/65
Date of Accident:	12/16/13

Dear Sir/Madam:

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Sincerely,

Cherry M. Vick

Cherry M. Vick
Legal Assistant
to Mark B. Tinsley

/cmv
enc

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH CARE INFORMATION AND REVOCATION OF ALL PRIOR AUTHORIZATIONS FOR RELEASE OF INFORMATION

In accordance with § 164.508 of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and as the person signing this consent, I understand that I am authorizing the providers named below to disclose protected Health Information (PHI), including but not limited to confidential health care records and medical bills to any employee of GOODING AND GOODING, PA or any other person designated by them in writing:

1. The names and specific identification of the individual whose PHI is to be disclosed:
   Patient Name: Angela Reynolds
   Patient SS#: 254-49-8037
   Patient DOB: 12/17/65

2. Name of specific identification of the person or class of persons authorized to disclose PHI:
   Provider: MUSC Medical Ctr.

3. A specific description of the information to be used or disclosed:

****

Any and all medical records, documents, and things concerning the above named individual

☐ For any period of time including from my date of birth through the date that you received this request.

☑ For dates of service from 12/16/13 to present

Including, but not limited to:

****

- ☑ Medical Records
- ☑ Medical Reports
- ☑ Lab Reports
- ☑ Prescription Records
- ☑ Patient Information
- ☑ Hospital Records
- ☑ Physicians' Notes
- ☑ Therapy Notes
- ☑ Correspondence from other Health Care Providers
- ☐ Billing and Insurance Records
- ☑ Private Files
- ☑ Records Received from Another Health Care Provider
- ☑ Correspondence Received from any other Law Firm
- ☑ X-Ray, MRI, CAT scan, PET scan films and other Diagnostic reports
- ☑ Consultation Reports
- ☑ Handwritten Notes
- ☑ Registration Forms
- ☑ Nurses' Notes
- ☑ Photographs
- ☑ Any and all Testing Records
- ☑ Any and All Psychiatric and Mental Health Records
- ☑ Notes on File Jackets
- ☑ Telephone Message Notes
- ☑ Work Restrictions
- ☑ Any other information that You possess regardless Whether it is formally Considered part of the Patient's medical chart

****

4. I understand that the information in the patient's health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. The name or other specified identification of the persons to whom the covered identity may make the disclosure:

Any Employee of GOODING AND GOODING, PA or any other person designated by them in writing. The information should be sent to:

Gooding and Gooding, P.A.
P. O. Box 1000
Allendale, SC 29810

6. A description of each purpose of the request use for disclosure:

The purpose of the request disclosure is to enable GOODING AND GOODING, PA to represent the undersigned for legal purposes regarding injuries sustained by the patient identified in paragraph 1.

7. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: UPON SETTLEMENT OF MY CASE.

8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about a disclosure of my health information, I can contact: _____ at _____

9. ***All Prior authorizations given by me for the release of information for any reason or purpose whatsoever, are hereby revoked,*** and I do request that no information, of any nature, be disclosed concerning the above name patient at any time to any one other than GOODING AND GOODING, PA or my health care provider, if applicable or someone designated by them in writing, unless pursuant to validly issued subpoena duces tecum or court order. Before releasing any information pursuant to a subpoena duces tecum or court order, I am requesting that you ensure compliance with the "satisfactory assurance of notice" requirements of §164.512 (e) of HIPAA. A copy of this consent and notation concerning the persons or agencies to whom disclosure was made shall be included with my original records.

10. **I am specifically requesting that you accept a photostatic copy of this consent as though it were the original.**

Signature Date: 1/13/14

If signed by Legal Representative, relationship to patient *Witness:* Cheryl M. Ha

INVOICE

166

GOODING & GOODING

265 BARNWELL HWY
PO BOX 1000
ALLENDALE, SC 29810-1000

Invoice #: 26780536

Inv. Date: 2/5/2014
Due Date: 2/15/2014
Terms: Net 10

Patient: REYNOLDS, ANGELA
Account #: 1310100
Claim/File #:

Shipping:
265 BARNWELL HWY
PO BOX 1000
ALLENDALE, SC 29810-1000

Facility: MEDICAL UNIVERSITY OF SOUTH CAROLINA

Description	Quantity	Unit Price	Extension
* Note: Hard Copy Page Count: 13	13	$0.00	$0.00
Basic Fee $15.00	1	$15.00	$15.00
Copy Charge $0.65 Pgs 1-30	13	$0.65	$8.45

Product Total:	$ 23.45	
Postage:	$ 1.52	
State Tax:		6.00%
City/local Tax:		2.00%
Sales Tax:	$ 2.00	(8.00%)
Grand Total:	$ 26.97	
Credits/Payments:	$ 0.00	
Amount Due:	**$ 26.97**	

Please Note: This information has been disclosed to you from records that may be protected by state and federal confidentiality rules (42 CFR, part 2). The federal rules prohibit you from making any further disclosure of protected information unless further disclosure is expressly permitted by written consent of the person to whom it pertains, or is otherwise permitted by 42 CFR, part 2.

Payment Options:

- Use your credit card online at payportal.iodincorporated.com
- Use your credit card by phone at 866-420-7455 Option 1
- By mail; please include the payment sheet (page 2) with your check to ensure that your payment is properly applied!

iod incorporated TaxID No. 65-0765287
PO Box 19072, Green Bay WI, 54307-9072
*Phone: 866-420-7455 Option 1 * Fax: 920-406-6537*

INVOICE

PAYMENT SHEET

PLEASE RETURN THIS WITH YOUR PAYMENT.

MAKE PAYMENT TO:

iod incorporated
PO Box 19072
Green Bay, WI 54307-9072

TaxID No. 65-0765287

Invoice No:	26780536
Requester:	GOODING & GOODING
Account #:	1310100
Patient Name:	REYNOLDS, ANGELA
Amount Due:	26.97

Amount Paid $

Check No

To make an online payment, please go to payportal.iodincorporated.com

GOODING & GOODING, P.A.

41137

IOD INCORPORATED
COST:PIPD/REYNOLDS,ANGELA

2/17/2014

26.97

PAYMENT RECORD

Atty2000

RECORDS/ANGELA REYNOLDS

26.97

29702 644864 (5/13)

017851

Rev 11/11

MUSC Health

Patient Information

Patient Name	Sex	DOB	SSN
Reynolds, Angela	Female	12/17/1965	xxx-xx-8037

ED Provider Notes signed by Edward Charles Jauch, MD MS at 12/30/2013 8:21 AM

Author:	Edward Charles Jauch, MD MS	Service:	Emergency Medicine	Author Type:	Physician
Filed:	12/30/2013 8:21 AM	Note Time:	12/16/2013 8:32 PM		
Related Notes:	Original Note by Elizabeth Page Bridges, MD filed at 12/17/2013 1:01 AM				

Procedure Orders:
1. INTUBATION [30100442] ordered by Elizabeth Page Bridges, MD at 12/16/13 2045

History

No chief complaint on file.

HPI Comments: 47 yoF with unknown past medical history presents as trauma activation. Patient was restrained passenger that struck logging truck on highway. On EMS arrival, patient alert to voice, improving by report. Complaining of abdominal pain.
Patient is a 48 y.o. female presenting with trauma. The history is provided by the EMS personnel.

Trauma

Mechanism of injury: **motor vehicle crash**
Injury location: **torso**
Arrived directly from scene: **yes**

Motor vehicle crash:
- Patient position: **front passenger's seat**
- Collision type: **front-end**
- Objects struck: **large vehicle**
- Speed of patient's vehicle: **highway**
- Death of co-occupant: **no**
- Steering column state: **broken**
- Restraint: **lap/shoulder belt**

EMS/PTA data:
- Bystander interventions: **none**
- Ambulatory at scene: **no**
- Responsiveness: **responsive to voice**
- Loss of consciousness: **yes**
- Airway interventions: **none**
- IV access: **established**
- Immobilization: **none**

Current symptoms:
- Associated symptoms:
  - Reports abdominal pain and loss of consciousness.

No past medical history on file.

No past surgical history on file.

No family history on file.

History
Substance Use Topics

- Smoking status: Not on file
- Smokeless tobacco: Not on file
- Alcohol Use: Not on file

Review of Systems
Unable to perform ROS: Mental status change
Gastrointestinal: Positive for abdominal pain.
Neurological: Positive for loss of consciousness.

Physical Exam

There were no vitals taken for this visit.

Physical Exam
Nursing note and vitals reviewed.
Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished.
Shallow breathing
HENT:
Head: Normocephalic and atraumatic.
Eyes: Pupils are equal, round, and reactive to light.
Pupils 3 mm, reactive
No malocclusion, no midface instability, no septal hematoma
Neck:
In C collar
Cardiovascular: Normal rate and regular rhythm.
Pulmonary/Chest: Breath sounds normal.
Shallow breathing, breath sounds equal bilaterally
Abdominal: Soft. There is tenderness (diffuse).
Neurological: She is alert and oriented to person, place, and time.
GCS 14 (Eye opening to voice)

ED Course

Intubation
Date/Time: 12/16/2013 8:45 PM
Performed by: BRIDGES, ELIZABETH PAGE
Authorized by: BRIDGES, ELIZABETH PAGE
Consent: The procedure was performed in an emergent situation.
Indications: respiratory failure and airway protection
Intubation method: video-assisted
Patient status: paralyzed (RSI)
Preoxygenation: nonrebreather mask
Sedatives: etomidate
Paralytic: succinylcholine
Laryngoscope size: D blade.

Tube size: 7.5 mm
Tube type: cuffed
Number of attempts: 1
Cricoid pressure: yes
Cords visualized: yes
Post-procedure assessment: chest rise and CO2 detector
Breath sounds: equal
Cuff inflated: yes
ETT to lip: 23 cm
Tube secured with: adhesive tape
Patient tolerance: Patient tolerated the procedure well with no immediate complications.

MDM
Number of Diagnoses or Management Options

Amount and/or Complexity of Data Reviewed
Clinical lab tests: ordered
Tests in the radiology section of CPT®: ordered and reviewed
Decide to obtain previous medical records or to obtain history from someone other than the patient: yes
Obtain history from someone other than the patient: yes (EMS)
Discuss the patient with other providers: yes (Trauma service (attending: Dr. Fann))
Independent visualization of images, tracings, or specimens: yes
Risk of Complications, Morbidity, and/or Mortality
Presenting problems: high
Diagnostic procedures: high
Management options: high

Clinical & Imaging Tests: Ordered & Reviewed

Labs
Lab Results

HEM PANEL (Final result) Abnormal Component (Lab Inquiry)

Result Time	WBC	RBC	HGB	HCT	MCV
12/16/13 20:31:00	22.44 (H)	3.14 (L)	8.7 (L)	26.6 (L)	84.7

Result Time	MCH	MCHC	RDW
12/16/13 20:31:00	27.7	32.7	13.8

PLATELET COUNT (Final result) Component (Lab Inquiry)

Result Time	PLT	MPV
12/16/13 20:31:00	370	10.30

CBC (Final result)

ABO/RH (In process)

ANTIBODY SCREEN (In process)

PROTIME-INR (In process)

APTT (In process)

BASIC METABOLIC PANEL (In process)

ETHANOL (In process)

Imaging

XR CHEST AP PORTABLE

Final Result:

IMPRESSION:

1. No evidence of acute intrathoracic trauma.

2. Recommend upright PA and lateral chest or CT when patient able
if concern for great vessel injury.

VOICE DICTATED BY: Dr. Brian Flemming
I have reviewed the study and agree with the findings in this report.

CT HEAD WO CONTRAST

Final Result:

IMPRESSION:
1. No acute intracranial process.

2. Right frontal and occipital scalp hematomas.

3. Orogastric tube curls within the nasopharynx.

4. Incidentally noted rounded metallic radiodensity within the
subcutaneous tissues anterior to the left maxillary sinus, likely a
BB. Correlate with physical-exam.

VOICE DICTATED BY: Dr. Brian Flemming
I have reviewed the study and agree with the findings in this report.

CT TRAUMA ANG NECK WITH CONTRAST (Results Pending)
CT CHEST ABDOMEN PELVIS W CONTRAST (Results Pending)

Assessment/Plan

47 yoF presents as trauma activation following MVC.

Primary survey: Airway intact, breath sounds bilaterally, femoral pulses 2+, GCS 14, PERRL
Although GCS >8, satting well, patient began to have very shallow breathing with poor air

movement. Patient with decreased responsiveness to questions. Decision made to intubate patient following completion of primary survey for respiratory distress and declining mental status.

Secondary survey: Abdomen tender. Pelvis stable.Patient holding left arm above head, in signficant pain with arm movement.

Admitted to STICU.

Attestations

I was present during the performance of the critical or key portion(s) of the service and I was directly involved in the management of the patient. I have reviewed the resident's note and I agree with the evaluation and documentation.

Resident's involved and supervised by me include: Dr. Bridges and the trauma team.

Elizabeth Page Bridges, MD
Resident
12/17/13 0101

Edward Charles Jauch, MD MS
12/30/13 0821

MUSC Health

HISPHYS

Trauma Center Initial Patient Evaluation

Form Origination Date: 4/04
Version: 4 Version Date: 12/11

P:499063600 DOB:12/17/1965 U F
REYNOLDS
ANGELA
Adm:12/16/13 M:2687999

PATIENT IDENTIFICATION LABEL

Date: 12/16/13 Time: 8:00 PM Trauma Notification Level: ☒ A ☐ B ☐ Consult
Primary Care Physician: _____

PREHOSPITAL DATA

Hospital transfer: ☐ Unknown ☒ No ☐ Yes- hospital name: _____
Mode of transport: ☒ Ambulance ☒ Helicopter ☐ Private Vehicle ☐ Other: _____
Injury Date: 12/16/13 Time of Injury: 7 PM
Patient age: 45 ☐ Male ☒ Female
Loss of consciousness: ☒ Yes How long? unknown min ☐ No ☐ Unknown
Prehospital course: same

Mechanism of Injury

☒ MVC ☐ Auto vs bicycle ☐ Motorcycle ☐ Stabbing ☐ Burn ☐ Fall: height _____
☐ Auto vs pedestrian ☐ Moped ☐ GSW ☐ Assault ☐ Hanging ☐ Other: _____

Position: ☒ Driver ☒ Front seat passenger ☐ Back seat passenger
Ejected: ☐ Yes ☒ No
Crash Type: ☒ Front ☐ Lateral ☐ Rollover ☐ Rear ☐ Fixed Object
Safety Equipment: ☒ Seatbelt ☐ Airbag ☐ Helmet

HISTORY OF PRESENT ILLNESS

45 y/o F restrained passenger MVC vs Truck ↓ Long bone deformities, (+) SOB and labored breathing, Intoxicated (+) LOC

PAST MEDICAL / SURGICAL HISTORY

(☒ check if unable to obtain due to need for urgent evaluation secondary to ☒ intubation ☐ unconscious)
Allergies: NKDA

Medications: complete medication reconciliation form

tylenol

Past Medical History: tubal ligation ϕ medical history
Surgical History: _____
Family History: Mother _____ Father _____ Siblings _____
Social History: Occupation _____ Marital Status married
Alcohol ☒ No ☐ Yes: _____
Tobacco ☒ No ☐ Yes: _____
Drugs ☒ No ☐ Yes: _____

REVIEW OF SYSTEMS (☒ check if unable to obtain due to need for urgent evaluation)

System	WNL	Abnormal (describe)
Constitutional	☐	
Eyes	☐	
Ears / Nose / Throat	☐	
Cardiac	☐	
Vascular	☐	
Respiratory	☐	
Gastrointestinal	☐	
Genitourinary	☐	
Musculoskeletal	☐	
Skin	☐	
Neurologic	☐	
Psychiatric	☐	
Endocrine	☐	
Hematologic / Lymphatic	☐	
Immunologic	☐	

MUSC Health

HISPHYS

Trauma Center Initial Patient Evaluation

Form Origination Date: 4/04
Version: 4 Version Date: 12/11

P499063600 DOB:01/01/1900 U
TRAUMA
QP VIC
EAdm:12/31/14 M2687999
PATIENT IDENTIFICATION LABEL

PRIMARY SURVEY

Airway: ☒ Patent and stable
☐ Unstable – actions taken: _____
Intubated: ☐ No ☐ Yes: intubated by: ☐ Anesthesia ☐ ED staff ☐ Trauma ☐ Outside hospital ☐ EMS

Breathing: ☒ Breath signs bilaterally – Annaskel
☒ Abnormalities – actions taken: intubated for respiratory failure (tachypnea, shallow breath sounds bilaterally, difficulty speaking)

Circulation: ☐ No signs or symptoms of shock, no external hemorrhage
☒ Abnormalities – actions taken: hypotensive en route – 3L NS via pressure bags

Disability: ☐ Glasgow Coma Score = 15
☐ Glasgow Coma Score < 15 – actions taken (if any): _____

Initial Glasgow Coma Score:
Eye opening: 4
Verbal response: 5
Motor response: 6
Total Coma score: 15

Eye	Verbal	Motor
4=open spontaneously	5=oriented, converses	6=obeys verbal command
3=open to verbal command	4=disoriented, converses	5=localizes to pain
2=open to pain	3=inappropriate responses	4=withdrawal from pain
1=no response	2=incomprehensible sounds	3=decorticate (flex) to pain
	1=no response	2=decerebrate (extend) to pain
		1=no response

				Deficit Right	Deficit Left
Pupils	Are pupils equal, round and reactive to light?	☒ Yes	☐ No, describe deficits:		
Facial symmetry	Is face symmetric?	☒ Yes	☐ No, describe deficits:		
Upper extremities	Side of dominance: ☒ Right	☐ Left	☐ Ambidextrous		
	Can patient lift arms off bed?	☒ Yes	☐ No, describe deficits:		
	Patient hand grip:	Right: ☒ Strong ☐ Weak ☐ Absent Left: ☒ Strong ☐ Weak ☐ Absent			
Lower extremities	Can patient lift legs off bed?	☒ Yes	☐ No, describe deficits:		
	Can patient bend knees?	☒ Yes	☐ No, describe deficits:		
	Can patient plantar flex?	☒ Yes	☐ No, describe deficits:		
	Can patient dorsi flex?	☒ Yes	☐ No, describe deficits:		
Sensation	Can patient feel arms?	☒ Yes	☐ No, describe deficits:		
	Can patient feel legs?	☒ Yes	☐ No, describe deficits:		

Resuscitation: — **Done Prior to Arrival**

☒ Peripheral IV lines — ☒
☒ Supplemental O_2 15 L — ☒
☐ Foley catheter placed — ☐
☐ NG tube — ☐
☐ OG tube — ☐
☒ Ventilator — ☐
☐ Chest tube (location): _____ — ☐
Inserted by: _____
Attending present: _____
☐ Central venous line (location): _____ — ☐
Inserted by: _____
Attending present: _____

Products / Fluids Given in Trauma Bay	Total Amount Given
Crystalloid IV	3 L
PRBC IV	
FFP IV	
Platelets IV	

P:499063600 DOB:12/17/1965 U F
REYNOLDS
ANGELA
Adm:12/16/13 M:2687999
PATIENT IDENTIFICATION LABEL

Physical Exam:

Initial vital signs:

BP 96/61 mmHg Pulse 88 bpm Resp 17 breaths/min
Temperature 36.0 °C SpO_2 100 % ☐ RA ☒ O_2 100 F O_2 L/min

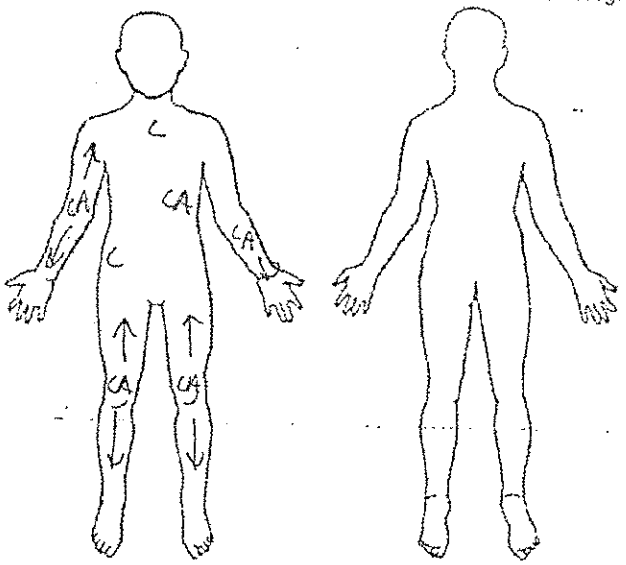
System	WNL	Abnormal (specify right, left or bilateral)
General	☐	☐ morbid obesity ☐ cachexia respiratory distress
Head	☒	
Scalp		
Facial skin		
Facial bones		
Mandible		
Eyes	☒	
Pupils		
EOMs		
Ears	☒	
TMs		
External auditory canals		
Pinna		
Nose	☒	
Nasal septum		
Mouth	☒	
Teeth		
Tongue		
Pharynx		
Mucous membranes		
Neck	☒	
Cervical spine		
Cervical collar in place?		☒ Yes ☐ No Cervical Collar placed prehospital? ☒ Yes ☐ No
Soft tissues		
Chest / Respiratory	☐	
Breath sounds		shallow bilaterally
Chest wall		multiple contusions / abrasions
Heart	☒	
Abdomen	☒	
Pelvis	☐	painful to palpation
Genitalia	☒	
Rectum including digital rectal exam	☒	
Back	☒	
Extremity examination: Upper extremities Lower extremities	☐	multiple contusions / abrasions throughout

Pulses	Radial	Femoral	Dorsalis Pedis	Posterior Tibial
Right	2+	2+	2+	2+
Left	2+	2+	2+	2+

P499063600 DOB:01/01/1900 U
TRAUMA
QP VIC
EAdm:12/31/14 M2687999
PATIENT IDENTIFICATION LABEL

Neurologic Exam	WNL	Abnormalities
CN II - XI	X	
Sensory	X	
Motor	X	
Skin:		multiple contusions/abrasions as documented below
Back or buttock skin breakdown or erythema	X	

Skin Exam:
A=abrasion C=contusion L=laceration B=burn S=surgical incision or scar P=penetrating / puncture wound



Minor Procedures Performed in Trauma Bay:

Repair of laceration(s):
- ☒ No
- ☐ Yes - Location of laceration(s) _____
- Repaired with: ☐ sutures ☐ staples ☐ other _____
- Service that repaired laceration: _____

Wound Irrigation / Debridement:
- ☒ No
- ☐ Yes - Location of wound(s) _____
- Service that performed procedure: _____

Other procedures done in trauma bay:
- Procedure: _____
- Location: _____
- Service that performed procedure: _____

FAST EXAM:
☐ Not Done ☒ Negative ☐ Equivocal ☐ Positive: location: _____

ANCILLARY STUDIES:

Labs:

ABG: 7.34 | 44 | 37 | 100 : | 23 | -2

Blood Alcohol Level: Neg.

Blood Type: Opos Neg

CBC: 22.4 → 8.7 / 26.6 → 370; 15.2 | 29.2 | 1.2

Urine or Serum HCG: _____

Trimester of pregnancy: _____

Chemistry: 142 | 110 | 17 / 3.0 | 23 | 1.1 → 53; 7.2

RADIOLOGY STUDIES: (write results in Assessment section)

	Outside Scans	Preliminary Read	Final Read
☒ CXR	☐	☒	☐
☐ Pelvis x-ray	☐	☐	☐
☐ Extremity x-ray	☐	☐	☐
☒ CT Brain	☐	☒	☐
☐ CT Face	☐	☐	☐
☒ CT C-spine	☐	☒	☐
☐ CT Angio Neck	☐	☐	☐
☒ CT Chest	☐	☒	☐
☒ CT Abdomen / Pelvis	☐	☒	☐
☐ Other _____	☐	☐	☐
☐ Other _____	☐	☐	☐

ASSESSMENT: INJURY LIST (in no particular order)

1. TBI / concussion
2. scattered contusions + abrasions
3. respiratory failure
4. R frontal and scalp hematomas
5. RSD chondral separate @ R rib 1-2, L rib 1.
6. Small R PTX S tube
7. Mandibular and inferior dental fx c assoc hematoma
8. Lower and mandible tear c active extravasation
9. Traumatic R flank hernia
10. Left L5 TP fx

MUSC Health

"HiSPHYS"

Trauma Center Initial Patient Evaluation

Form Origination Date: 4/04
Version: 4 Version Date: 12/11

P:499063600 DOB:12/17/1965 W F
REYNOLDS
ANGELA
Adm:12/16/13 M:2687999

PATIENT IDENTIFICATION LABEL

PLAN:

1. Admit to STICU
2. vent for resp failure / propofol gtt
3. pain control
4. Log eval when extubated
5. lovenox
6. foley
7. QUH iOc
8. Cog eval when able

Disposition:

- ☐ Home
- ☐ Observation
- ☒ Inpatient
  - ☐ Floor ☒ ICU
- ☐ Morgue
- ☐ Transfer to other facility _____

CONSULTS	REASON FOR CONSULT	RESIDENT NOTIFIED	TIME OF NOTIFICATION	ATTENDING ON CALL
Orthopaedic Surgery				
Neurosurgery				
OMFS				
Plastic Surgery				
ENT				
Ophthalmology				
CT Surgery				
Vascular Surgery				
Urology				
Interventional Radiology				
Other:				
Other:				

Operating Room Notified: ☒ NO ☐ YES TIME NOTIFIED: _____

Clinician Signature/Initials _____ Pager ID 15252 Date 12/16/13 Time 21:00

Clinician Signature/Initials _____ Pager ID _____ Date / / Time _____

ah_critcare_doc traumahp

OTE 700557 Rev. 12/11

MUSC Health

HISPHYS

Trauma Center Initial Patient Evaluation

Form Origination Date: 4/04
Version: 4 Version Date: 12/11

P:499063600 DOB:12/17/1965 U F
REYNOLDS
ANGELA
Adm:12/16/13 M:2687999

PATIENT IDENTIFICATION LABEL

MUSC Trauma Center Initial Patient Evaluation

Attending Physician's Statement

Attending Statement: The patient has been seen and examined by me personally. I have reviewed the documentation from resident: ____________ and a discussion of the history and physical findings has been held.

I can confirm the following key history facts: Patient single vehicle MVC (passenger) [illegible] brought by EMS. Hypotensive in field but responded to fluid. GCS 14-15 RUE arm pain

I have examined the patient and key findings include: GCS 15, Respiratory failure [illegible] NWOA, Patient intubated in trauma bay for [illegible]. BS + bilaterally. No PTX by CXR, FAST negative. Multiple bruises to extremities, [illegible]. Hypotension in bay [illegible] SBP c intubation but MAP 76 and [illegible] HR.

Gustilo open fracture classification ____________ ☐ N/A

PRESENT ON ADMISSION: ☐ shock: ☐ traumatic ☐ hypovolemic ☐ hemorrhagic ☐ cardiogenic
☐ pulmonary insufficiency following trauma ☐ cerebral edema ☐ brain compression ☐ coma

Assessment: Blunt Force Trauma, Chest c Respiratory failure, Multiple Contusions [illegible].

Plan: ATLS Evaluation, CT Head, C-spine, CAP, ICU admission & Ventilator Management [illegible] pending CT results

Patient Condition: ☐ Critical / Unstable ☒ Serious ☐ Fair ☐ Good
Admission Type: ☒ Inpatient ☐ Observation
This document is serving as:
☒ Admission History and Physical ☐ Emergency Dept. Evaluation ☐ Consultation (service consulting): ____________
☐ Critical Care Time Without Procedures: ____________

I have personally reviewed all available radiographic images:	☒ Yes	☐ No
I have reviewed the results of pertinent laboratory tests:	☒ Yes	☐ No
I have personally reviewed the results of additional medical testing and monitor output:	☒ Yes	☐ No
I have personally discussed this case with the family:	☐ Yes	☐ No

Risk of complications / mortality: ☐ Minimal ☐ Low ☐ Moderate ☒ High

Signature: [signature] Date: 12/17/13 Time: 8:30

☐ Samir Fakhry, MD	Pager 14007	☐ Stuart Leon, MD	Pager 14339	☒ Stephen Fann, MD	Pager 14238
☐ E. Douglas Norcross, MD	Pager 14223	☐ Stephanie Montgomery, MD	Pager 14030	☐ ____________	Pager ____
☐ Bruce Crookes, MD	Pager 14602	☐ Evert Eriksson, MD	Pager 14761		

ah_critcare_docu_traumahp

OTE 700557 Rev. 12/11

MUSC Health

Medication Reconciliation Database

Admission Documentation

Page 1 of 1

Form Origination Date: 7/06

Version: 10

Version Date: 9/13

"HISPHYS"

P:499063600 DOB:12/17/1965 U F

REYNOLDS

ANGELA

Adm:12/16/13 M:2687999

Patient Name Trauma QP

MRN 2687999

PATIENT INFORMATION LABEL

PROHIBITED ABBREVIATIONS: qd, qod, U, IU, MS, MS04, MgS04, µg, drug names.
Do not write a whole number with a trailing zero. Do not write a decimal point without a leading zero.

Ht (cm): _____ Wt (kg): _____

ALLERGIES / REACTIONS (specify any medication, food, or product & the type of reaction) ☒ None

~~NKDA~~

HOME MEDICATIONS: ☐ No home medications ☐ Unknown home medications

Continue on admission Yes	Continue on admission No	Home Medication Name	Dose	Route	Frequency	Reason Taking	Last Dose (Date & Time)
☐	☒	Tylenol		By mouth			
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						

UNIT STAFF: FAX TO PHARMACY Signature _____ Date _____ Time _____ AM/PM

Physician Signature _____ Pager ID 15253 Date 12/16/13 Time 20:33 AM/PM

medreconciliation

Copy to Orders section of Medical Record

OTE 900538 Rev. 9/13

GOODING AND GOODING
A PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW

265 BARNWELL HIGHWAY
CORNER OF BARNWELL HIGHWAY AND MEMORIAL AVENUE
POST OFFICE BOX 1000
ALLENDALE, SOUTH CAROLINA 29810

H. WOODROW GOODING
ELIZABETH KEARSE GOODING
MARK B. TINSLEY

LAINE BRABHAM GOODING

Telephone #
(803) 584-7676

Facsimile #
(803) 584-3614

December 30, 2013

MUSC Medical Center
Health Information Services Dept.
ATTN: Release of Information
171 Ashley Avenue
Charleston, SC 29425-0768

16a Ashley Ave. MSC 349
16a Ashley Ave. MSC 349
Charleston, SC 29425
Fax 843-792-7202

Re: William E. Reynolds, Jr.
SS: 239-21-1037
DOB: 02/02/60
Date of Accident: 12/16/13

Dear Sir/Madam:

Please be advised that GOODING AND GOODING, P.A. represents the legal interest of the individual named above, as a result of injuries sustained in an automobile accident on the above referenced date. It is my understanding that our client received medical treatment at your facility on or after 12/16/13. I would appreciate your forwarding a copy of the ER report and Admission report. I am enclosing a medical authorization for the release of this information.

Sincerely,

Cherry M. Vick

Cherry M. Vick
Legal Assistant
to Mark B. Tinsley

/cmv
enc

1/8/14

Spoke to representative they have the request. The billing was processed on 1/3/14 + records 1/6 it will take 2 wks. for me to get.

1/31/14 Billing

GOODING AND GOODING
A PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW

264 BARNWELL HIGHWAY
POST OFFICE BOX 1000
ALLENDALE, SOUTH CAROLINA 29810

H. WOODROW GOODING
ELIZABETH KEARSE GOODING

LAINE BRABHAM GOODING
MARK B. TINSLEY

Telephone #
(803) 584-7676

Facsimile #
(803) 584-3614

December 30, 2013

MUSC Health Info. Services
Attn: Copy Med
169 Ashley Ave.
P.O. Box 250349
Charleston, S.C. 29425

Re: William E. Reynolds, Jr.
SS: 239-21-1037
DOB: 02/02/60
Date of Accident: 12/16/13

Dear Sir/Madam:

Please be advised that GOODING and GOODING, P.A., represents the above named individual as a result of injuries sustained in an automobile accident. It is our understanding that treatment was provided in your facility for these injuries on or after the above date. I would appreciate your forwarding an ITEMIZED BILL for ER services and Admission rendered on 12/16/13. I am enclosing a properly executed medical authorization for the release of this information.

Sincerely,

Cherry M. Vick

Cherry M. Vick
Legal Assistant
to Mark B. Tinsley

/cmv
enc

INVOICE

Invoice #: 26684383

Inv. Date: 1/27/2014
Due Date: 2/6/2014
Terms: Net 10

GOODING & GOODING

265 BARNWELL HWY
PO BOX 1000
ALLENDALE, SC 29810-1000

Patient: REYNOLDS JR, WILLIAM
Account #: 1310100
Claim/File #:

Shipping:
265 BARNWELL HWY
PO BOX 1000
ALLENDALE, SC 29810-1000

Facility: MEDICAL UNIVERSITY OF SOUTH CAROLINA

Description	Quantity	Unit Price	Extension
* Note: Hard Copy Page Count: 33			
Basic Fee $15.00	33	$0.00	$0.00
Copy Charge $0.65 Pgs 1-30	1	$15.00	$15.00
Copy Charge $0.50 Pgs 31+	30	$0.65	$19.50
	3	$0.50	$1.50

Product Total:	$ 36.00	
Postage:	$ 2.12	
State Tax:		6.00%
City/local Tax:		2.00%
Sales Tax:	$ 3.05	(8.00%)
Grand Total:	$ 41.17	
Credits/Payments:	$ 0.00	
Amount Due:	**$ 41.17**	

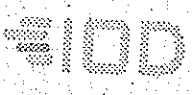
Please Note: This information has been disclosed to you from records that may be protected by state and federal confidentiality rules (42 CFR, part 2). The federal rules prohibit you from making any further disclosure of protected information unless further disclosure is expressly permitted by written consent of the person to whom it pertains, or is otherwise permitted by 42 CFR, part 2.

Payment Options:

- Use your credit card online at payportal.iodincorporated.com
- Use your credit card by phone at 866-420-7455 Option 1
- By mail; please include the payment sheet (page 2) with your check to ensure that your payment is properly applied!

Iod incorporated TaxID No. 65-0765287
PO Box 19072, Green Bay WI, 54307-9072
*Phone: 866-420-7455 Option 1 * Fax: 920-406-6537*

INVOICE



PAYMENT SHEET

PLEASE RETURN THIS WITH YOUR PAYMENT.

MAKE PAYMENT TO:

iod incorporated
PO Box 19072
Green Bay, WI 54307-9072

TaxID No. 65-0765287

Invoice No:	26684383
Requester:	GOODING & GOODING
Account #:	1310100
Patient Name:	REYNOLDS JR, WILLIAM
Amount Due:	41.17

Amount Paid $

Check No

To make an online payment, please go to payportal.iodincorporated.com

GOODING & GOODING, P.A.

IOD INCORPORATED
COST:PIPD/REYNOLDS, WILLIAM E. JR.

41138

2/17/2014

41.17

PAYMENT RECORD

Atty2000

RECORDS/WILLIAM E. REYNOLDS, JR.

41.17

29702: 644864 (5/13)

017851

Rev 11/11

MUSC Health

Patient Information

Patient Name	Sex	DOB	SSN
Reynolds Jr, William E	Male	2/2/1960	xxx-xx-1037

ED Provider Notes signed by Edward Charles Jauch, MD MS at 12/16/2013 8:56 PM

Author:	Edward Charles Jauch, MD MS	Service:	Emergency Medicine	Author Type:	Physician
Filed:	12/16/2013 8:56 PM	Note Time:	12/16/2013 8:34 PM		
Related Notes:	Original Note by Blair Buck Turnage, PAC filed at 12/16/2013 8:41 PM				

History

No chief complaint on file.

HPI Comments: The patient was the restrained driver who ran his car into the back of a large truck. The patient steering column broke into the patient's chest. The patient was brought in via EMS protecting his airway complaining of chest pain, low back pain and right ankle pain.

Patient is a 113 y.o. unknown presenting with motor vehicle accident. The history is provided by the patient. No language interpreter was used.

Motor Vehicle Crash

The accident occurred less than 1 hour ago. He came to the ER via EMS. At the time of the accident, he was located in the driver's seat. He was restrained by a shoulder strap. The pain is present in the chest, lower back and right ankle. The pain is moderate. The pain has been constant since the injury. Associated symptoms include chest pain and shortness of breath. Pertinent negatives include no numbness, no visual change, no abdominal pain, no disorientation, no loss of consciousness and no tingling. There was no loss of consciousness. The accident occurred while the vehicle was traveling at a high speed. The vehicle's windshield was shattered after the accident. The vehicle's steering column was broken after the accident. He was not thrown from the vehicle. The vehicle was not overturned. The airbag was deployed. He was not ambulatory at the scene.

No past medical history on file.

No past surgical history on file.

No family history on file.

History

Substance Use Topics

- Smoking status: Not on file
- Smokeless tobacco: Not on file
- Alcohol Use: Not on file

Review of Systems

Respiratory: Positive for shortness of breath.
Cardiovascular: Positive for chest pain.
Gastrointestinal: Negative for abdominal pain.

Neurological: Negative for tingling, loss of consciousness and numbness.
All other systems reviewed and are negative.

Physical Exam

There were no vitals taken for this visit.

Physical Exam
Nursing note and vitals reviewed.
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished.
HENT:
Head: Normocephalic and atraumatic.
Right Ear: External ear normal.
Left Ear: External ear normal.
Eyes: EOM are normal. Pupils are equal, round, and reactive to light.
Neck:
Cervical collar in place
Pulmonary/Chest: Effort normal.
Decreased breath sounds on the right
Abdominal: Soft. He exhibits distension. He exhibits no mass. There is tenderness. There is no rebound and no guarding.
FAST scan negative
Musculoskeletal:
Patient with right ankle pain
Back board in place and cervical collar in place

Neurological: He is alert and oriented to person, place, and time.
Skin: Skin is warm and dry.
Midline chest abrasion from where steering wheel broke into his chest
Psychiatric: He has a normal mood and affect. His behavior is normal. Judgment and thought content normal.

ED Course

Procedures

MDM
Number of Diagnoses or Management Options
MVC (motor vehicle collision): new and requires workup
Diagnosis management comments: Trauma A was called
General surgery is at bedside
labs are ordered
EKG ordered and FAST scan negative

Amount and/or Complexity of Data Reviewed
Clinical lab tests: ordered and reviewed
Tests in the radiology section of CPT®: ordered and reviewed
Discussion of test results with the performing providers: yes
Decide to obtain previous medical records or to obtain history from someone other than the patient: yes
Obtain history from someone other than the patient: yes
Review and summarize past medical records: yes

Discuss the patient with other providers: yes
Independent visualization of images, tracings, or specimens: yes
Risk of Complications, Morbidity, and/or Mortality
Presenting problems: high
Diagnostic procedures: high
Management options: high
Patient Progress
Patient progress: stable

Clinical & Imaging Tests: Ordered & Reviewed

Labs

Lab Results

HCG, SERUM, QUANT (In process)

BASIC METABOLIC PANEL (In process)

ETHANOL (In process)

APTT (Final result)

Component (Lab Inquiry)

Result Time	APTT
12/16/13 20:39:00	26.6 Reference ranges for infants less than or equal to 30 days are for full term healthy infants only. Call laboratory (792-0707) to obtain reference range values for premature healthy infants. The recommended aPTT therapeutic range for the treatment of Deep Vein Thrombosis (DVT) or Pulmonary Embolus (PE) using Unfractionated Heparin is 61 - 105 seconds which is equivalent to 0.3 - 0.7 Anti-Xa units/ml. ..... Brill Edwards correlation of anti-Xa level to aPTT is as follows: ..... Anti-Xa (U/mL) = aPTT (seconds) 0.1 U/mL = 43.0 seconds 0.2 U/mL = 52.3 seconds 0.3 U/mL = 61.0 seconds 0.4 U/mL = 73.1 seconds 0.5 U/mL = 83.6 seconds 0.6 U/mL = 94.0 seconds 0.7 U/mL = 105.0 seconds 0.8 U/mL = 114.9 seconds 0.9 U/mL = 125.3 seconds 1.0 U/mL = 135.7 seconds The Activated Partial Thromboplastin time (aPTT) is to be used for monitoring Direct Thrombin Inhibitor Therapy. The therapeutic range for these anticoagulants is 1.5 - 2 times the patient's base line aPTT.

PROTIME-INR (Final result)

Component (Lab Inquiry)

Result Time	PROTHROMBIN TIME	INR
12/16/13 20:39:00	14.5 In patients on warfarin therapy, the range for therapeutic INR (1.5 - 3.5) will depend on the clinical disorder being treated. Effective 2/27/2013, the critical PT value which corresponds to an INR of 3.51 changes from 35.5 sec to 35.2 sec due to the yearly lot number changes in reagent used for PT testing and subsequent reagent	1.13

sensitivity (ISI) used to calculate INR values. Test methodology and reagent remain unchanged.

HEM PANEL (Final result) Abnormal Component (Lab Inquiry)

Result Time	WBC	RBC	HGB	HCT	MCV
12/16/13 20:32:00	20.64 (H)	5.53	15.8	46.2	83.5

Result Time	MCH	MCHC	RDW
12/16/13 20:32:00	28.6	34.2	12.6

PLATELET COUNT (Final result) Component (Lab Inquiry)

Result Time	PLT	MPV
12/16/13 20:32:00	296	9.90

CBC (Final result)

ABO/RH (In process)

ANTIBODY SCREEN (In process)

ARTERIAL POINT OF CARE PANEL (Final result) Abnormal Component (Lab Inquiry)

Result Time	FIO2, CAP, POC	TEMPERATURE, CAP, POC	PH	PCO2, CAP, POC	PO2, CAP, POC
12/16/13 20:16:00	100	36.8	7.29 (L)	54 (H)	351 (H)

Result Time	BICARBONATE, CAP, POC	BASE EXC/DEF, CAP, POC	TOTAL CO2, CAP, POC	O2 SATURATION, CAP, POC	SODIUM, CAP, POC
12/16/13 20:16:00	26	-2	27	100 (H)	138

Result Time	K	GLUCOSE, CAP, POC	HGB	HCT	CALCIUM IONIZED, CAP, POC
12/16/13 20:16:00	3.6	307 (H)	15.6	46	1.17

Result Time	PERFORMING LAB, ART, POC
12/16/13 20:16:00	See Note MUSC Medical Center, 171 Ashley Avenue, Charleston, SC,29425

Imaging

XR CHEST AP PORTABLE

Final Result: IMPRESSION:

1. Hazy right lower lobe airspace opacity which could represent
contusion or aspiration.

2. Mildly displaced fracture of the right fifth rib with a right pleural effusion.

3. Transverse fracture of the middle third of the left clavicle.

4. Slight prominence of the superior mediastinal silhouette, likely
accentuated by portable technique. Recommend upright PA and lateral
chest or CT when patient able if concern for great vessel injury.

VOICE DICTATED BY: Dr. Brian Flemming
I have reviewed the study and agree with the findings in this report.

CT TRAUMA ANG NECK WITH CONTRAST (Results Pending)
CT CHEST ABDOMEN PELVIS W CONTRAST (Results Pending)
CT HEAD WO CONTRAST (Results Pending)

ED Medications: Ordered, Reviewed & Administered

ED Medications
Medications - No data to display

Home Medications
No current facility-administered medications on file prior to encounter.

No current outpatient prescriptions on file prior to encounter.

ED Consults
No orders of the defined types were placed in this encounter.

EKG Interpretation

Assessment
The patient is undergoing imaging and is admitted to the general surgery service in the STICU

Clinical Impression
1. MVC (motor vehicle collision)

Plan

1. admit to STICU

Attestations

I have had meaningful face-to-face contact with the patient. I have reviewed the Non-Physician Practitioner note and I agree with the evaluation and documentation. Additional elements include:discussed with trauma service.

Blair Buck Turnage, PAC
12/16/13 2041

Edward Charles Jauch, MD MS
12/16/13 2056

MUSC Health

Patient Information

Patient Name	Sex	DOB	SSN
Reynolds Jr, William E	Male	2/2/1960	xxx-xx-1037

ED Consult signed by Robert Holmes, MD at 12/16/2013 11:59 PM

Author:	Robert Holmes, MD	Service:	Orthopaedic: Orthopaedic Surgery	Author Type:	Resident
Filed:	12/16/2013 11:59 PM	Note Time:	12/16/2013 11:38 PM	Cosign Required:	Yes

Orthopedic Initial Encounter
Ortho Attending: Glaser
Date of Consult: 12/16/2013
Consulted by: Trauma Service

CC: MVC

HPI: Eddie Reynolds is a 53 y.o. male s/p MVC vs. Logging truck with +LOC. The patient and his wife were traveling to Beaufort for his wife's birthday when a logging truck crossed the median and struck their car. They were brought here by EMS. Orthopaedics was consulted for a knee laceration and concern for an arthrotomy, along with Widening of the disc space between T8-9. The patient reports pain in his back and in his chest, but denies any other pain at other locations. He inquires about his wife, who was apparently taken for ex-lap by general surgery. He reports that he had a previous C5-6 fusion for a previous fracture.

PAST MEDICAL HISTORY:
DM II
HTN
Fusiform brain aneurysm

SURGICAL HISTORY:
C5-C6 fusion
Meniscectomy
Gallbladder
Carpal tunnel

SOCIAL HISTORY:
History

Social History
- Marital Status: Unknown
  - Spouse Name: N/A
  - Number of Children: N/A
- Years of Education: N/A

Occupational History
- Not on file.

Social History Main Topics
- Smoking status: Not on file

- Smokeless tobacco: Not on file
- Alcohol Use: Not on file
- Drug Use: Not on file
- Sexually Active: Not on file

Other Topics — Concern
- Not on file

Social History Narrative
- No narrative on file

FAMILY HISTORY: No family history on file.

MEDS:
Metformin
Metoprolol
Claritin

Allergies: Allergies no known allergies

ROS: As per HPI

PHYSICAL EXAM:
There were no vitals filed for this visit.
GEN: NAD, A&Ox3, c collar in place
Eyes: EOMI, conj wnl
HENT: clear, normocephalic
Neck: supple, tender of the paraspinal musculature
Resp: non-labored, chest wall tender to palpation
Psyc: normal mood and thought process
Skin: laceration over R knee 10 cm in length
MSK: focused musculoskeletal exam reveals:

LUE--> WWP, BCR, SILT M/U/R, +AIN/PIN/M/U/R, full range of motion about the shoulder, elbow, wrist, and fingers. 2+ radial pulse. Non-tender throughout. No gross deformity.

RUE--> WWP, BCR, SILT M/U/R, +AIN/PIN/M/U/R, full range of motion about the shoulder, elbow, wrist, and fingers. 2+ radial pulse. Non-tender throughout. No gross deformity.

LLE-->WWP, BCR, SILT S/S/SP/DP/T, +EHL/FHL/G/S/TA, full range of motion about the hip, knee, and ankle. Knee is stable to varus/valgus/anterior drawer/posterior drawer/lachmans. 2+DP/PT. Compartments soft. Non-tender throughout. No gross deformity.

RLE-->WWP, BCR, SILT S/S/SP/DP/T, +EHL/FHL/G/S/TA, full range of motion about the hip, knee, and ankle. Knee is stable to varus/valgus/anterior drawer/posterior drawer/lachmans. 2+DP/PT. Compartments soft. Ankle tender to palpation. No gross deformity.

Pelvis--stable

Spine - mildly tender to palpation over thoracic spine

LABS:
Recent Labs

12/10/13 — 12/10/13

	2010	2016
WBC	20.64*	--
HCT	46.2	46
PLT	296	--

]
Recent Labs

	12/16/13 2010	12/16/13 2016
NA	138.0	--
K	3.60	3.6
CL	103.0	--
BUN	13.0	--
GLU	--	307*

]
Recent Labs

	12/16/13 2010
INR	1.13

]
No results found for this basename: ESR, CRP, in the last 72 hours]

IMAGING:
CT spine showing widening of T8-9 vertebrae
XR R foot showing possibly chronic base of 5th metatarsal fracture

ASSESSMENT:
Eddie Reynolds is a 53 y.o. male sp MVC with identified injuries as follows: bilateral rib fractures, small epidural hematoma, widening of T8-9 vertebrae, chronic vs acute Jones fracture of base of the 5th metatarsal. Significant laceration over R knee, 100cc of saline injected into knee joint, saline load test negative, no evidence of arthrotomy

PLAN:

-Full spine precautions
-MRI spine when able to assess for ligamentous injury
-Hard soled shoe for base of 5th MT fracture
-Recommendations were communicated verbally to the consulting team.

MUSC Health

IP-H & P

William E Reynolds Jr (MR# 002688007)

IP-H & P Info

Author	Note Status	Last Update User	Last Update Date/Time
Avery Lee Buchholz, MD	Signed	Avery Lee Buchholz, MD	12/16/2013 11:45 PM

IP-H & P

HISTORY AND PHYSICAL FOR ADMISSION

Eddie Reynolds is a 53 y.o. male
MRN: 002688007

CHIEF COMPLAINT: MVC

HPI

Eddie Reynolds is a 53 y.o. male sp MVC. Patient had positive LOC but presents to ED GCS 15. Patient was found to have multiple fractures of ribs and long bones and was also found to have an intracranial hemorrhage.

Patient denies headache, vision changes, numbness, tingling or weakness but does have some neck pain.

ACTIVE PROBLEMS

There is no problem list on file for this patient.

ALLERGIES

Allergies as of 12/16/2013

- (No Known Allergies)

CURRENT OUTPATIENT MEDICATIONS:

Continue on admission			
YES	NO		INDICATION
		No current outpatient prescriptions on file.	

PAST MEDICAL HISTORY

Reported R fusiform aneurysm followed by neurosurgeon at UNC. No bleeds. Diagnosed with R side hearing loss.

PAST SURGICAL HISTORY

No past surgical history on file.

FAMILY HISTORY

family history is not on file.

SOCIAL HISTORY

REVIEW OF SYSTEMS
NEURO: negative
Negative except HPI
On anticoagulation medications:No

PHYSICAL EXAM

GEN:in no apparent distress	ABD:negative
ENT:no discharge, swelling or lesions noted}	GU:normal
CV:normal rate, regular rhythm, normal S1, S2, no murmurs, rubs, clicks or gallops	EXT:peripheral pulses normal, no pedal edema, no clubbing or cyanosis
PULM:Respiratory effort normal. Lungs clear bilaterally.	SKIN:no rashes

NEUROLOGIC EXAM:

Orientation:Oriented to person, place, time and situation
EYE: 4 - Opens eyes on own
VERBAL: 5 - Alert and oriented
MOTOR:6 - Follows simple motor commands
GCS Score: 15

Cranial Nerves

II - visual fields were intact, equal, round, and reactive to light	VIII - vibratory stimulus response was normal bilaterally
III, IV, & VI - all extraocular movements were intact	IX & X - gag reflex intact bilaterally
V - facial sensation was normal and symmetrical	XI - shoulder shrug strength appeared normal bilaterally
VII - eye closure was normal bliaterally	XII - tongue protrusion was midline, no fasciculations noted

Motor exam:normal 5/5 strength in all tested muscle groups

Reflexes

Pronator Drift Right: absent
Pronator Drift Left: absent
DTR patellar 1+
Other:

IMAGING

LABS
Lab Results

Component	Value	Date
WBC	20.64*	12/16/2013
HCT	46	12/16/2013
PLT	296	12/16/2013

INR	1.13	12/16/2013
NA	138.0	12/16/2013
K	3.6	12/16/2013
CL	103.0	12/16/2013
CREATININE	1.1	12/16/2013
BUN	13.0	12/16/2013

ASSESSMENT/PLAN: Eddie Reynolds is a 53 y.o. male with R side SDH.

- Patient admitted to trauma surgery.

Follow Q1H neuro exams and supportive care with SBP less than 150

Will repeat CT scan 6 hrs from original or sooner with neuro decline.

Will need approval prior to any surgical procedure if needed.

PRINCIPAL DIAGNOSIS
No diagnosis found.

Signed
Avery Lee Buchholz, MD
11:40 PM, 12/16/2013
Pager ID: 15821

Chart Cosign

Signed By
Bruce M. Frankel, MD

Signed At
Tue Dec 17, 2013 11:47 AM EST

MUSC Health

Patient Information

Patient Name	Sex	DOB	SSN
Reynolds Jr, William E	Male	2/2/1960	xxx-xx-1037

Transcription

Type	ID	Status	Author
Operative Note	59251565720131220093	Authenticated	John A. Glaser, MD

Transcription Text

MUSC Medical Center
OPERATIVE NOTE

PATIENT NAME: REYNOLDS, EDDIE
MRN: 002688007
PATCOM: 499063675
DATE OF SURGERY: 12/19/2013
SERVICE: Surgery, Orthopedic
SURGEON: John Glaser, MD
ASSISTANTS: John William Neal, MD

PREOPERATIVE DIAGNOSIS: Unstable T8-9 fracture with mild extension deformity.

POSTOPERATIVE DIAGNOSIS: Unstable T8-9 fracture with mild extension deformity with pulmonary compromise.

PROCEDURE: Posterior percutaneous stabilization T7-T10 utilizing DePuy Viper pedicle screw system with 6.0 x 40 mm screws and 5.5 x 100 mm titanium rods, CPT is 22842.

PREOPERATIVE SITUATION: This is a gentleman who was in a motor vehicle accident. He suffered the above-mentioned injury with concomitant rib fractures and sternal fracture. He had remained stable and then transferred to the floor. He was brought to the operating room for posterior open fixation and bone grafting of his unstable injury. He has comorbidity of obesity and insulin-dependent diabetes.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room and was placed under adequate general endotracheal anesthesia. TEDs and SCDs were in place. Foley catheter was in place. Attempts were made to place him in the prone position on bolsters, but he had significant desaturation that did not resolve. He was placed back in the supine position. His desaturation resolved. We then discussed the situation with the Anesthesia Department and decided upon attempting to do lateral position with percutaneous fixation and bone grafting at a later date. We placed him in the lateral position with the right side down and he once again had severe desaturation. We placed him in the supine position. The Trauma Team was called and Dr. Leon was kind enough to come into the room and assess the situation. He performed a bronchoscopy and repositioning of the endotracheal tube

with improvement in saturation. At this point, we decided upon fixation without fusion so that we could avoid the prone position. He was placed back in the lateral position on the Jackson table with no significant desaturation. The operative site was sterilely prepped and draped. A time-out was called. Appropriate parameters were verified between nursing, surgical, and anesthesia staff.

Image intensifier was brought into position and we used Jamshidi needles to cannulate the pedicles of T7, 8, 9 and 10 bilaterally that were checked in the AP and lateral planes. This was followed by a wire and placement by wires and then tap and placement of screws on towers. We also had the motor and sensory evoked potentials running throughout the case by verbal report. The lower extremities were normal at the beginning and throughout the case.

After screws were placed, we selected 100 mm rods and placed these from cephalad to caudal through all of the screws. We placed the locking nuts. We used some reduction maneuvers if need be. We had also bent the rod so that they were in slight kyphosis to try to reduce the extension deformity. We tightened the locking nuts and removed the various towers and screwdrivers. The image intensifier showed appropriate position in the AP and lateral planes of the bony elements and the hardware. A motor-evoked potential was run, and by verbal report, it was normal in the lower extremities. The wounds were irrigated and closed with deeper layers of Vicryl and skin of a Monocryl. There were 8 percutaneous incisions for placement of the screws. This was followed by a dressing. The plan will be for mobilization as tolerated and being transferred back to the Intensive Care Unit, intubated for close monitoring of his respiratory status. We will plan on bone grafting at a later date. Blood loss was minimal. On the AP image intensifier, the left T7 screw did appear somewhat lateral to the pedicle but was felt to be acceptable in his situation and had good clinical purchase.

Dictated by: John Glaser, MD

_____

John Glaser, MD
Surgeon

592515657/medq/
JOB: 1166703
DD: 12/19/2013 18:01:38
DT: 12/20/2013 09:32:08
Electronically Authenticated by:
JOHN GLASER, MD On 12/20/2013 09:45 AM EST

Original Documentation: 0000 12/19/2013 Operative Note By: Hpf Defaultprovider

MUSC Health

Patient Information

Patient Name	Sex	DOB	SSN
Reynolds Jr, William E	Male	2/2/1960	xxx-xx-1037

Transcription

Type	ID	Status	Author
Operative Note	59259766920131221031	Authenticated	Stuart M. Leon, MD

Transcription Text

MUSC Medical Center
OPERATIVE NOTE

PATIENT NAME: REYNOLDS, EDDIE
MRN: 002688007
PATCOM: 499063675
DATE OF SURGERY: 12/19/2013
SERVICE: Surgery, Traumatic
SURGEON: Stuart M Leon, MD
ASSISTANTS:

PREOPERATIVE DIAGNOSES:
1. Hypoxia.
2. Mucus plugging.

POSTOPERATIVE DIAGNOSES:
1. Hypoxia.
2. Mucus plugging.

TITLE OF PROCEDURE: Bronchoscopy and aspiration of tracheobronchial tree.

FIRST ASSISTANT: Yana Mikhaylov, MD

ANESTHESIA: General endotracheal anesthesia.

OPERATIVE INDICATIONS: The patient is a 53-year-old gentleman who was involved in a motor vehicle collision on December 16th of this year. The patient was brought to MUSC for trauma evaluation. He was found to have a traumatic brain injury with subdural hematoma as well as bilateral rib fractures and a ligamentous injury to his thoracic spine. The patient is currently in the operating room, and he has desaturated twice, once when attempted to be placed in the prone position and a second time when placed into the lateral decubitus position. For his anticipated spinal fusion in order to stabilize his back. Given these findings, we have elected to perform a bronchoscopy in order confirm placement of the endotracheal tube as well as rule out mucous plugging as the cause of the patient's hypoxia.

OPERATIVE FINDINGS: Thick tenacious secretions within the distal trachea as well as a mucous plugging of the left mainstem bronchus.

OPERATIVE TECHNIQUE: The patient was in the operating room. He was on the operating table in the supine position. He was already under general endotracheal anesthesia, and was receiving full mechanical ventilatory support. The bronchoscope was then passed through the patient's indwelling endotracheal tube and advanced into the distal airway. Upon passing through the end of the endotracheal tube which was noted to be in excellent position, the patient was noted to have thick copious secretions and mucus within the distal trachea, and these were able to be successfully aspirated out. The right mainstem bronchus was visualized and appeared to be clear from secretions, the bronchoscope was quickly passed into the right upper, middle, and lower lobe subsegmental bronchi and no significant secretions were encountered within these airways. The bronchoscope was then withdrawn back to the carina and then advanced into the left mainstem bronchus. Here thick tenacious mucous plugs were encountered and these were able to be aspirated out of the airways. Once all of these mucus plugs had been aspirated out of the airway, the bronchoscope was then passed sequentially into the left upper lingular and lower lobe subsegmental bronchi, and again the distal airways were clear from secretions. The bronchoscope was removed. The patient tolerated this procedure well without incident and remained intubated in the operating room awaiting his planned spinal fusion.

ATTESTATION STATEMENT: I, Stuart M Leon, MD, was personally present and supervised all aspects of this procedure from beginning to end.

Dictated by: Stuart M Leon, MD

_____
Stuart M Leon, MD
Surgeon

592597669/medq/
JOB: 1166832
DD: 12/20/2013 11:41:55
DT: 12/21/2013 03:13:35
Electronically Authenticated by:
STUART LEON, MD On 12/30/2013 06:11 AM EST

Original Documentation: 0000 12/19/2013 Operative Note By: Hpf Defaultprovider

MUSC Health

Patient Information

Patient Name	Sex	DOB	SSN
Reynolds Jr, William E	Male	2/2/1960	xxx-xx-1037

Transcription

Type	ID	Status	Author
Operative Note	593292170201312280 30	Authenticated	Langdon A. Hartsock, MD

Transcription Text

MUSC Medical Center
OPERATIVE NOTE

PATIENT NAME: REYNOLDS, EDDIE
MRN: 002688007
PATCOM: 499063675
DATE OF SURGERY: 12/27/2013
SERVICE: Orthopedics
SURGEON: Langdon A Hartsock, MD
ASSISTANTS: Stephen Charles Stacey, MD

PREOPERATIVE DIAGNOSIS: Right displaced fifth metatarsal fracture.

POSTOPERATIVE DIAGNOSIS: Right displaced fifth metatarsal fracture.

PROCEDURE: Open reduction and internal fixation, right fifth metatarsal fracture.

ANESTHESIA: General endotracheal/regional.

ESTIMATED BLOOD LOSS: None.

DRAINS: None.

COMPLICATION: None.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room and after the successful induction of general anesthesia, the patient was positioned supine on the OR table with a bump under the right hip. The right lower extremity was prepped and draped in sterile field. Preoperative antibiotics were given.

The right leg was elevated and exsanguinated with an Esmarch bandage and the tourniquet was inflated to 300 mmHg. An incision was made over the fifth metatarsal at the fracture, which was at the junction between the proximal metaphysis and the diaphysis. The fracture was displaced and separated approximately 1 cm. The fracture site was identified. Hematoma was evacuated. The fracture was anatomically reduced. A percutaneous guidewire was inserted on the lateral aspect of the foot and directed from the tip of the fifth metatarsal into the intramedullary canal. Correct position was confirmed on AP, lateral,

and oblique image intensifier visualization. The cannulated drill was applied and then a 50 mm long partially threaded 4.5-mm cannulated screw was placed over the guidewire with excellent reduction and fixation of the fracture. The guidewire was removed. Image intensifier views in the AP, lateral, and oblique projections showed satisfactory reduction and fixation of the fifth metatarsal fracture.

The patient also had a minimally displaced fracture of the cuboid and fractures of the metatarsal bases and proximal phalanges of the lesser toes. These were treated non operatively. The wounds were irrigated with saline. The wounds were closed with 3-0 Vicryl and 3-0 nylon. Sterile dressings were applied. Tourniquet was released. Plain x-rays were obtained. The foot and lower leg were placed into a well-padded posterior splint stirrup. He was awakened from anesthesia and transported to the recovery room in stable condition.

Dictated by: Langdon A Hartsock, MD

_____

Langdon A Hartsock, MD
Surgeon

593292170/medq/
JOB: 1167843
DD: 12/27/2013 12:54:11
DT: 12/28/2013 02:57:53
Electronically Authenticated by:
LANGDON A HARTSOCK, MD On 12/30/2013 03:58 PM EST

Original Documentation: 0000 12/27/2013 Operative Note By: Hpf Defaultprovider

MUSC Health

IP-Discharge

William E Reynolds Jr (MR# 002688007)

IP-Discharge Info

Author	Note Status	Last Update User	Last Update Date/Time
Keller Earnst, FNP	Signed	Keller Earnst, FNP	1/13/2014 10:34 AM

IP-Discharge

DISCHARGE SUMMARY

Eddie Reynolds is a 53 y.o. male.
MRN: 002688007

DATE OF ADMISSION: 12/16/13
DATE OF DISCHARGE: *1/13/14*

ATTENDING PHYSICIAN: Dr. Fann
SERVICE: Trauma

REASON FOR ADMISSION: Patient was involved in a motor vehicle crash and sustained multiple injuries.

Past Medical History

Diagnosis	Date
• Hypertension	
• Diabetes mellitus type 2 in obese	
• Seasonal allergies	
• Aneurysm, cerebral	
• Multiple fractures of ribs of right side	3-7, 9
• Open left clavicular fracture	
• Injury Of Thoracic Spine *s/p percutaneous stabilization*	
• SDH (subdural hematoma) *R frontal*	
• Cuboid fracture *R subluxation*	
• Metatarsal bone fracture *R 5th*	
• Fracture of rib of left side *9*	
• Multiple fractures of foot	
• Pleural effusion on right *s/p chest tube placement 12/23*	
• Right chylothorax	

Past Surgical History

Procedure	Laterality	Date
• Cholecystectomy		
• Cervical discectomy *C5-C6*		
• Knee surgery *right*		
• Carpal tunnel release		

• Closure of right knee laceration	12/17/2013
• Bronchoscopy	12/19/2013
• T7-t10 percutaneous stabilization	12/19/2013
• Orif metatarsal fracture *R displaced 5th*	12/27/2013

History

Social History

• Marital Status:	Married
Spouse Name:	N/A
Number of Children:	N/A
• Years of Education:	N/A

Occupational History
- police officer

Social History Main Topics

• Smoking status:	Never Smoker
• Smokeless tobacco:	Not on file
• Alcohol Use:	No
• Drug Use:	No
• Sexually Active:	Yes -- Female partner(s)

Other Topics — Concern
- Not on file

Social History Narrative
- No narrative on file

Family History

Problem	Relation	Age of Onset
• Heart disease	Mother	
• Prostate cancer	Father	

PROCEDURE(S): *see below:*
12/17/13 (Fann) closure of right knee laceration
12/19/13 (Leon) bronchoscopy
12/19/13 (Glaser) posterior percutaneous stabilization T7-T10
12/27/13 (Hartsock) ORIF right fifth metatarsal fracture
1/2/14 (Denlinger) ligation of thoracic duct

HOSPITAL COURSE:

H and P: For full details please see history and physical in chart. Briefly, patient was admitted on 12/16/13 as a trauma notification level A. Patient was transported to MUSC via helicopter. Patient did sustain + LOC. Mechanism of injury: MVC. Primary survey: A - airwar patient and stable, B - breath sounds B, C - no s/s shock, no external hemorrhage, D - GCS 15. Patient was fully evaluated in the trauma bay and was found to have the following injury complex: clavicle fx, pulmonary contusions, rib fractures, T8-9 splaying, SDH. Neurosurgery, Orthopedics, and Ortho

Spine were consulted and their recommendations were followed. Patient was started on the rib fracture protocol. He was placed on Lovenox for DVT prophylaxis. Patient was admitted to the STICU for further monitoring.

Hospital Course:
STICU 12/16/13 - 12/21/13: please see transfer summary/discharge summary in Epic or Transcriptions from 12/21/13.

Patient was transferred out to the floor briefly. On the morning of 12/23, patient had chest pain, dizziness, abdominal pain, shortness of breath. A CXR showed a worsening right pleural effusion so patient was transferred to the ICU for chest tube placement and further monitoring.

STICU 12/23/13 - 12/24/13: see transfer summary from 12/24/13

Patient was transferred out to the floor on 12/24/13. We continued neuro checks and the rib fracture protocol. His chest tube was in place, on suction, and he was placed on a fat free diet for his chylothorax. Patient went to the OR with Dr. Hartsock on 12/27/13 for open reduction and internal fixation, right fifth metatarsal fracture. He tolerated the procedure well and was transferred back to the floor. DMS was also consulted for the patient's hyperglycemia. On the morning of 12/31/13 patient was having desaturations, tachycardia, and decreased responsiveness. He was therefore transferred to the ICU for further care.

STICU 12/31/13 - 1/1/14: see transfer summary from 1/1/14

Patient was transferred back to the floor on 1/1/4. CT Surgery continued to follow the patient and patient went to the operating with Dr. Denlinger on 1/2/14 for a thoracic duct ligation. Please see below for further details on remaining hospital course.

1. SDH/TBI: NSG signed off while the patient was in the ICU. No dilantin needed per nsgy. His neuro exams remained stable and had no acute neurosurgical needs. Patient may follow up with Dr. Frankel as needed as an outpatient. SLP was consulted and performed a cognition evaluation which was WNL.

2. Clavicle fx: Orthopedics continued to follow the patient for his clavicle fx which is non-op. He has a sling to LUE for comfort and is NWB to LUE. Occupational Therapy was consulted and their recs were followed.

3. Rib fractures: Patient was on the rib fracture protocol and received aggressive pulmonary toileting and incentive spirometer use. His pain continued to be well controlled and he was transitioned to po pain medication prior to discharge.

4. T8-T9 splaying: Patient underwent posterior percutaneous stabilization T7-T10 on 12/19/13 by Dr. Glaser. Patient does not need a spine brace. We obtained post-mobilization films that were stable and patient will follow up with Dr. Glaser in 2 weeks.

5. R foot fracture: Patient went to the OR with Dr. Hartsock on 12/27/13 for open reduction and internal fixation, right fifth metatarsal fracture. He is NWB to RLE. He has a CAM boot in place and his sutures were discontinued prior to discharge. Physical therapy was consulted and worked with the patient during his stay. He will follow up in the McBanks clinic in 1 month.

6. Respiratory failure/Hemothorax/Pneumothorax/Chylothorax: Patient was transferred out of the ICU with a chest tube in place. He continued to have large volumes of drainage from his chest tube despite his fat free diet. Therefore, we consulted CT Surgery for their recommendations. Patient went to the OR for Dr. Denlinger on 1/2/14 for a thoracic duct ligation. He tolerated the procedure well and was transferred back to the floor. Patient received fluid replacements with IVF. Patient was

slowly advanced to a CHO diet as his chest tube output continued to slowly decreased. His chest tube was placed to water seal, CXR's remained stable, and was eventually discontinued by CT sgy on 1/9/14. His post pull CXR showed no pneumothorax. Patient should follow up with Dr. Denlinger in 2 weeks.

7. Fever/leukocytosis: On the evening of 1/9/14, patient was found to be febrile and tachycardic with new oxygen requirement and leukocytosis (WBC 21.5). CT chest showed moderate bilateral pleural fluid collections, with multiple loculations and gas/fluid levels seen on the right. CXR with increased consolidation on the right side. Patient continued to look well clinically on 1/10/14. CT surgery saw the patient and felt there was no intervention needed for the pleural fluid collections. They would like the patient to follow up with Dr. Denlinger in 2 weeks with a repeat CXR. His WBC continued to decrease and his fevers resolved. WBC 10.3 on 1/13. Patient educated to continue aggressive IS use and frequent ambulation/OOB at home. Patient did have a oxygen walk test prior to discharge which revealed desaturation to 84%. Therefore patient will be discharged home on Oxygen.

8. Deconditioning: PT/OT/SLP continued to follow the patient. They have cleared the patient for home with a FWW.

9. Hyperglycemia: DMS was consulted and their recs were followed. Please see final discharge instructions from DMS.

Patient is now ready for discharge home. He has cleared PT and is tolerating a regular diet. His pain is well controlled on po pain medication. He will be discharged home with family.

DISCHARGE LABS:

Lab Results

Component	Value	Date
WBC	21.53*	1/10/2014
HGB	13.1*	12/23/2013
HCT	32.1*	1/10/2014
PLT	259	1/10/2014
NA	133.0*	1/10/2014
K	3.40*	1/10/2014
CL	96.0*	1/10/2014
CREATININE	0.7	1/10/2014
BUN	5.0*	1/10/2014
INR	1.28	12/31/2013
HGBA1C	7.8	12/28/2013

ALLERGIES:

Allergies as of 01/10/2014

- (No Known Allergies)

CANCER STAGING: n/a

MEDICATION RECONCILIATION

Medications upon admission:

Outpatient Prescriptions Prior to Visit

Medication	Sig	Dispense	Refill
• lisinopril (PRINIVIL, ZESTRIL) 10 MG tablet	Take 10 mg by mouth daily.		
• loratadine (CLARITIN) 10 mg tablet	Take 10 mg by mouth daily.		
• metFORMIN (GLUCOPHAGE)	Take 1 tablet by mouth 2 (two)	60 tablet	3

500 MG tablet	times daily with meals.
• metoprolol (LOPRESSOR) 25 MG tablet	Take 25 mg by mouth 2 times daily.

No facility-administered medications prior to visit.

Medications stopped during this admission:
There are no discontinued medications.

Medications added during this admission:
No medications were ordered in this visit.

Medications at discharge:
Metoprolol 12.5mg po q 12 hrs
Cetirizine 10mg po daily
Atorvastatin 80mg po daily
Aspirin 325mg po daily
Gabapentin 400mg po TID
Oxycodone 5mg 1-3 tabs po q 4 hrs prn pain#150
Tamsulosin 0.4mg po daily
Senna 8.6 mg po BID
Colace 100mg po BID
Metformin 500mg po BID

DISCHARGE DIAGNOSIS, PROBLEMS, PLANS:

Problem List — Date Reviewed: **1/10/2014**

	Codes
Hypertension	401.9
Seasonal allergies	477.9
Diabetes mellitus type 2 in obese	250.00, 278.00
Aneurysm, cerebral	437.3
Multiple fractures of ribs of right side	807.09
Open left clavicular fracture	810.10
Injury Of Thoracic Spine	952.10
SDH (subdural hematoma)	432.1
Cuboid fracture	825.23
Metatarsal bone fracture	825.25
Fracture of rib of left side	807.00
Multiple fractures of foot	825.20
Pleural effusion on right	511.9
Right chylothorax	457.8

Primary discharge dx: rib fractures, clavicle fracture, T8-9 splaying, right foot fx, respiratory failure, pneumothorax, hemothorax, chylothorax, hypovolemic shock, SDH, right knee laceration, fever, leukocytosis, hypokalemia, hyponatremia, acute blood loss anemia
Secondary dx: HTN, HLD, hyperglycemia
Incidental findings: right inguinal hernia, 2 radiolucent foci within marrow spaces of C4 and C2; Patient has been given a copy of his CT scans and told to follow up with his PCP for his incidental findings and MRI if indicated.
Level of activity: perform breathing exercises using IS q 2 hrs while awake, walk with assistance or device, do not drive or operate machinery when taking narcotics
Weight Bearing Status: right leg NWB
Diet: Regular
Wound care: surgical incisions: clean with soap and water,ok to shower
Call for the following: temperature greater than 101.5, diarrhea or constipation for more than 2 days, numbness or tingling, any increased drainage or foul odor, or green drainage from wound, nausea

or vomiting, shortness of breath lasting greater than 5 minutes, pain not controlled with pain meds, dizziness or feeling light headed.
CAM boot to right foot. No flying in airplane or scuba diving x 6 weeks.
Patient phone number: 910-791-9029, 910-200-8937
Patient is being discharged with home oxygen.

PATIENT'S DISPOSITION: Home or self care
Home services required: None front wheeled walkeer

PLANNED FOLLOW-UP:
PCP of choice 1 weeks hospital follow up and incidental findings
Trauma: Dr. Fann as needed hospital follow up
Neurosurgery: Dr. Frankel as needed SDH
CT Surgery: Dr. Denlinger 2 weeks chylothorax, with repeat CXR (order placed in Epic)
Orthopedics: McBanks 1 month foot fracture, clavicle fx
Orthopedics Spine: Dr. Glaser 2 weeks spine fracture

Chart Cosign

Signed By	Signed At
Stephen A Fann, MD	Wed Jan 15, 2014 9:23 AM EST

MUSC Health

IP-Discharge

William E Reynolds Jr (MR# 002688007)

IP-Discharge Info

Author	Note Status	Last Update User	Last Update Date/Time
Maria Psomas Jones, PA	Signed	Maria Psomas Jones, PA	1/8/2014 2:23 PM

IP-Discharge

DIABETES DISCHARGE INSTRUCTIONS

EDDIE REYNOLDS
MRN: 002688007
DOB: 2/2/1960
53 y.o. male
Patcom: 499063675

ORAL DIABETES MEDICATIONS: Metformin 500mg twice daily with meals.
INSULIN INSTRUCTIONS:

	BREAKFAST	LUNCH	SUPPER	9:00 PM	NOTE
When to check blood sugar	x		x		Test Blood Sugar before eating

A1C Value:

Lab Results

Component	Value	Date
HGBA1C	7.8	12/28/2013

DISCHARGE APPOINTMENTS:
Schedule the following: Please see your primary care provider within the next 1-2 weeks. Please keep a log of your blood sugars and bring the log to your appointment.

If your blood sugar is **less than 70mg/dl or greater than 300 mg/dl (especially if frequently outside the range of 70-300) and you have been recently discharged then please call the endocrine fellow on call through **MUSC paging operator at 843-792-2300** and ask them to page the **"endocrine fellow on call."** If you are a patient in our clinic then please call **843-792-2529** during office hours to speak with clinic staff.

Chart Cosign

Signed By	Signed At
Beatrice Janulyte Hull, MD	Thu Jan 9, 2014 9:21 AM EST

MUSC Health

IP-Consult

William E Reynolds Jr (MR# 002688007)

IP-Consult Info

Author	Note Status	Last Update User	Last Update Date/Time
Tahlia Leigh Weis Sadoski, MD	Addendum	Chadrick Evan Denlinger, MD	1/1/2014 9:46 AM

IP-Consult

INPATIENT CONSULTATION

Eddie Reynolds is a 53 y.o. male.
MRN: 002688007

Date of Service: 12/31/2013
Consulting Service: Thoracic Surgery

Requested by Attending Dr. Privette
Service requesting consult: STICU/Trauma

CHIEF COMPLAINT/REASON FOR CONSULT:
Chief Complaint
Patient presents with
- Shortness of Breath

HPI Comments: Patient is a 53 yo WM police officer who was admitted as a Trauma Level A 12/16/2013 following MVC (personal automobile versus log truck). The patient was awake and alert when triaged in the trauma bay and was found to have the injury complex noted in the problem list. He has undergone several surgeries during his hospitalization. Per review of records and report from the primary team, the patient had a right chest tube placed on 12/23 with immediate return of 3.5 L serosanguinous fluid for increasing pleural effusion noted on chest x-ray and respiratory insufficiency. The patient was noted to have continued serosanguinous output until after his chest tube was placed to waterseal on 12/27, when he was noted to have a milky output in his pleurovac cannister. The patient 's output quickly changed back to serosanguinous output for three days after being started on a chylothorax diet and he was given a food challenge yesterday, which resulted in immediate output of > 4 L of milky pink fluid. The patient has since had a heart rate up to the 140s with low blood pressures associated with increased respiratory effort and difficulty breathing.

Thoracic Surgery was consulted to evaluate for possible surgical intervention of the patient's right chylothorax. The patient was transferred to the ICU for worsening respiratory status, tachycardia, and hypotension that was not responsive to 2L of fluid bolus and suspected septic shock related to a leukocytosis of 39.58 from 8.94.

Shortness of Breath
This is a new problem. The current episode started in the past 7 days. The problem occurs constantly. The problem has been gradually worsening. Associated symptoms include chest pain and leg swelling. Pertinent negatives include no abdominal pain, fever, headaches, vomiting or wheezing. Risk factors include recent leg injury and prolonged immobilization. The treatment provided significant relief. His past medical history is significant for allergies and a recent surgery.

ACTIVE PROBLEMS:

Patient Active Problem List
Diagnosis

- Hypertension
- Seasonal allergies
- Diabetes mellitus type 2 in obese
- Aneurysm, cerebral
- Multiple fractures of ribs of right side
- Open left clavicular fracture
- Injury Of Thoracic Spine
- SDH (subdural hematoma)
- Cuboid fracture
- Metatarsal bone fracture
- Fracture of rib of left side
- Multiple fractures of foot
- Pleural effusion on right
- Right chylothorax

ALLERGIES:

Allergies as of 12/31/2013

- (No Known Allergies)

PREADMISSION OUTPATIENT MEDICATIONS:

Current Outpatient Prescriptions on File Prior to Visit

Medication	Sig	Dispense	Refill
• lisinopril (PRINIVIL, ZESTRIL) 10 MG tablet	Take 10 mg by mouth daily.		
• loratadine (CLARITIN) 10 mg tablet	Take 10 mg by mouth daily.		
• metFORMIN (GLUCOPHAGE) 1000 MG tablet	Take 500 mg by mouth 2 (two) times daily with meals.		
• metoprolol (LOPRESSOR) 25 MG tablet	Take 25 mg by mouth 2 times daily.		

INPATIENT MEDICATIONS:

NPO, NS@150 cc/h

Acetaminophen 650 mg po q4hb
Aspirin 325 mg po daily
Atorvastatin 80 mg po daily
Cetirizine 10 mg po daily
Docusate sodium 100 mg po bid
Enoxaparin 30 mg sc q12h
Gabapentin 400 mg po tid
Insulin regular human drip
Metoprolol tartrate 12.5 mg po q12h
Senna 8.6 mg po bid
Tamsulosin 24hr sr cap 0.4 mg po daily

Bisacodyl suppository 10 mg rect on call
Hydromorphone inj 0.5-1 mg iv q2h prn
Nitroglycerin sl 0.4 mg sl q5min prn

Ondansetron 4 mg iv q4h prn
Oxycodone 5-15 mg po q2h prn

PAST MEDICAL HISTORY: has a past medical history of Hypertension; Diabetes mellitus type 2 in obese; Seasonal allergies; Aneurysm, cerebral; Multiple fractures of ribs of right side (3-7, 9); Open left clavicular fracture; Injury Of Thoracic Spine; SDH (subdural hematoma); Cuboid fracture; Metatarsal bone fracture; Fracture of rib of left side; Multiple fractures of foot; Pleural effusion on right; and Right chylothorax.

SURGICAL HISTORY:
Past Surgical History

Procedure	Laterality	Date
• Cholecystectomy		
• Cervical discectomy *C5-C6*		
• Knee surgery *right*		
• Carpal tunnel release		
• Closure of right knee laceration		12/17/2013
• Bronchoscopy		12/19/2013
• T7-t10 percutaneous stabilization		12/19/2013
• Orif metatarsal fracture *R displaced 5th*		12/27/2013

SOCIAL HISTORY: reports that he has never smoked. He does not have any smokeless tobacco history on file. He reports that he does not drink alcohol or use illicit drugs.

FAMILY HISTORY: family history includes Heart disease in his mother and Prostate cancer in his father.

REVIEW OF SYSTEMS:
Review of Systems
Constitutional: Positive for fatigue. Negative for fever, chills, diaphoresis, activity change and appetite change.
HENT: Negative.
Eyes: Negative.
Respiratory: Positive for shortness of breath. Negative for apnea, cough, choking, chest tightness, wheezing and stridor.
Cardiovascular: Positive for chest pain and leg swelling. Negative for palpitations.
Gastrointestinal: Negative for nausea, vomiting, abdominal pain, diarrhea, constipation and abdominal distention.
Endocrine: Negative.
Genitourinary: Positive for difficulty urinating. Negative for dysuria, urgency, frequency and hematuria.
Musculoskeletal: Negative.
Skin: Negative.
Allergic/Immunologic: Positive for environmental allergies.
Neurological: Positive for tremors. Negative for dizziness, seizures, syncope, light-headedness, numbness and headaches.
Hematological: Negative.

Psychiatric/Behavioral: Negative.

PHYSICAL EXAM:
BP 95/68 | Pulse 116 | Temp(Src) 98.8 °F (37.1 °C) | Resp 20 | SpO2 92%
Physical Exam
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished. No distress.
HENT:
Head: Normocephalic and atraumatic.
Eyes: Conjunctivae are normal. Pupils are equal, round, and reactive to light. No scleral icterus.
Neck: Normal range of motion. Neck supple. No tracheal deviation present.
Cardiovascular: Regular rhythm, normal heart sounds and intact distal pulses.
No murmur heard.
Tachycardic to 140 during examination, though the patient had just been transferred to his ICU bed and rolled several times for RN assessment.
Pulmonary/Chest: Effort normal. No stridor. No respiratory distress. He has no wheezes. He has no rales. He exhibits tenderness.
Patient is wearing a non-rebreather with non-distressed respiratory effort. Decreased breath sounds along bilateral lung bases, anteriorly. Chest tube is intact along the right axillary line, attached to a pleurovac to waterseal that is completely full of pink milky fluid. No air leak noted upon forced expiration.
Abdominal: Soft. He exhibits distension. There is no tenderness. There is no rebound and no guarding.
Hypoactive bowel sounds.
Genitourinary: Penis normal.
Musculoskeletal:
Cast along right lower extremity. Palpable DP along LLE - capillary refill < 2 seconds bilateral lower extremities.
Lymphadenopathy:
He has no cervical adenopathy.
Neurological: He is alert and oriented to person, place, and time.
Skin: Skin is warm and dry. He is not diaphoretic.
Psychiatric: He has a normal mood and affect. His behavior is normal. Judgment and thought content normal.

LABS RESULTED: *Below is the patient's most recent value for WBC, Hemoglobin, Hematocrit, Platelet, Sodium, Potassium, Chloride, CO2, BUN, Creatinine Serum, GFR, Glucose, Calcium, Magnesium, Phosphorus, Intact PTH, Albumin, AST, ALT, Cholesterol, Triglycerides, HDL, LDL, and Hemoglobin A1C.*
Lab Results

Component	Value	Date
WBC	30.43*	12/31/2013
HGB	13.1*	12/23/2013
HCT	41.5*	12/31/2013
PLT	565*	12/31/2013
NA	132.0*	12/31/2013
K	6.00*	12/31/2013
CL	95.0*	12/31/2013
BUN	12.0	12/31/2013
GLU	153*	12/23/2013
MG	1.7	12/31/2013
PHOS	3.9	12/31/2013

RADIOLOGY REVIEWED: Chest x-ray with scant bilateral pleural effusions - chest tube is well-placed with tip at apex and side port at costopleural margin.

RECOMMENDATIONS:: 53 yo WM with evidence of right chylothorax, likely hypovolemic shock as the patient is negative 9.5 L over the past 48 hours, with profound hyperkalemia and leukocytosis.
- NPO, IVF
- agree with CT thorax, PE protocol, per primary team
- keep chest tube to -20 suction for now
- chest tube output ~100 cc/h since 5 am, continue to watch and replace to maintain euvolemia after volume resuscitation
- octreotide 100 mcg sc q8h
- will continue to follow, patient may need a VATS thoracic duct ligation in the future if continued high output from chest tube

ATTENDING NOTE:
I have examined Mr. Reynolds and agree with the note above.
Following a MVA he had a thoracic spine injury that was stabilized. He now has a chylothorax with a very large output. Two days ago, while on a regular died, he drained 4500 ml. He is now NPO and octreotide was started yesterday. In the past 24 hrs he has drained 1300, 800, 500 ml each 8 hrs and he has drained 600 in the past 5 hrs. He is now hemodynamically stable. Based on the persistent high output, he will likely need a VATS ligation of the thoracic duct. We will plan on doing this in the main hospital tomorrow (1/2/2014). He does have medical comorbidities including diabetes and hypertension. He denies any cardiac history and reported having stress tests and a heart cath that were reportedly normal. He denies angina with his typical activity, but his lifestyle in not really active. We discussed the risks and benefits of surgery. The greatest risk is persistent drainage following the ligation. Although I do not have the records from his prior cardiac evaluation, The persistent, very high chest tube output indicates that the chyle leak will not stop on its own and that a surgical intervention will be required.

Greater than 55 minutes were required for the evaluation of Mr. Reynolds and greater than 50% of this time was required for counseling and coordination of care.

Links
Previous Version

Chart Cosign

Signed By	Signed At
Chadrick Evan Denlinger, MD	Fri Jan 10, 2014 12:04 PM EST

MUSC Health

IP-Consult

William E Reynolds Jr (MR# 002688007)

IP-Consult Info

Author	Note Status	Last Update User	Last Update Date/Time
Nebras Alsaygh, MD	Addendum	Linda Maidment Meyers, MD	12/30/2013 4:57 PM

IP-Consult

INPATIENT CONSULTATION

Eddie Reynolds is a 53 y.o. male.
MRN: 002688007

Date of Service: 12/29/13
Consulting Service: Endocrinology

Service requesting consult: Gen Surgery

CHIEF COMPLAINT/REASON FOR CONSULT:
Chief Complaint
Patient presents with
- Diabetes

HPI 53M h/o DMII, HTN, HLD who was involved in a motor vehicle accident leading to a subdural hematoma, b/l rib fx and ligamentous injury to his thoracic spine s/p closure of right knee laceration, s/p posterior percutaneous stabilization T7-T10 with course c/b frequent desaturations s/p bronchoscopy revealing copious secretions and mucus s/p chest tube.
Endocrinology team was consulted for management of diabetes .

He is diabetic for the last 3 years
Home:
Metformin 1g po bid
BG check : once a week And range between 200 to 300
Has diabetic neuropathy .

Today : pt. Is doing good with no new complaints, eating well with no complication .

ACTIVE PROBLEMS: There is no problem list on file for this patient.

ALLERGIES:
Allergies as of 12/29/2013
- (No Known Allergies)

PREADMISSION OUTPATIENT MEDICATIONS:
No current outpatient prescriptions on file prior to visit.

REVIEW OF SYSTEMS:
Review of Systems
Constitutional: Negative for activity change, appetite change and fatigue.
HENT: Negative.
Eyes: Negative.
Respiratory: Negative.
Cardiovascular: Negative.
Gastrointestinal: Negative.
Endocrine: Negative.
Skin: Negative.
Neurological: Negative for tremors, weakness and numbness.
Psychiatric/Behavioral: Negative.

PHYSICAL EXAM:
Physical Exam
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished.
Neck: Normal range of motion. Neck supple. No thyromegaly present.
Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses.
Pulmonary/Chest: Effort normal and breath sounds normal.
Abdominal: Soft. Bowel sounds are normal.
Musculoskeletal: He exhibits edema.
Lymphadenopathy:
He has no cervical adenopathy.
Neurological: He is alert and oriented to person, place, and time.
Skin: Skin is warm.
Psychiatric: He has a normal mood and affect.

There were no vitals filed for this visit.

LABS RESULTED: *Below is the patient's most recent value for WBC, Hemoglobin, Hematocrit, Platelet, Sodium, Potassium, Chloride, CO2, BUN, Creatinine Serum, GFR, Glucose, Calcium, Magnesium, Phosphorus, Intact PTH, Albumin, AST, ALT, Cholesterol, Triglycerides, HDL, LDL, and Hemoglobin A1C.*

Lab Results

Component	Value	Date
WBC	8.94	12/29/2013
HGB	13.1*	12/23/2013
HCT	34.4*	12/29/2013
PLT	428	12/29/2013
NA	136.0	12/29/2013
K	3.80	12/29/2013
CL	101.0	12/29/2013
BUN	6.0*	12/29/2013
GLU	153*	12/23/2013
MG	2.0	12/29/2013
PHOS	4.0	12/29/2013

Lab Results

Component	Value	Date
HGBA1C	7.8	12/28/2013
HGBA1C	8.4	12/17/2013

Lab Results